TITLE 20: CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT
CHAPTER VII: SEX OFFENDER MANAGEMENT BOARD

PART 1910
JUVENILE SEX OFFENDER EVALUATION AND TREATMENT

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Section

AUTHORITY: Illinois Sex Offender Management Board Act [20 ILCS 4026].

SOURCE: Adopted at 33 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

Section 1910.10 Purpose

a) In 1997, the Illinois General Assembly approved legislation that established the Sex Offender Management Board. Since its inception, the Board has been charged with protecting victims and enhancing community safety. The purpose of this Part is to establish requirements for the evaluation, treatment, and monitoring of juvenile sex offenders to achieve these goals.

b) The following principles were developed to guide individuals and groups toward practices and systems that achieve the Board's goal of "no more victims":

1) Sexual abuse causes harm, and the safety of the community is paramount to any policy or practice concerning juveniles who commit sexual offenses.

2) All juveniles adjudicated for a sex offense described in Section 10 of the Sex Offender Management Board Act [20 ILCS 4026/10] must be provided a comprehensive evaluation designed specifically for juveniles who commit sexual offenses.

3) Comprehensive evaluation and treatment shall address the full range of the juvenile's sexually inappropriate behaviors, legal or illegal, and holistically describe the juvenile who commits sex offenses, including identifying the youth's strengths, weaknesses and needs.

4) A multidisciplinary team shall be established to ensure that the juvenile's need for treatment, supervision, and management and the victim's need for safety and well-being are met.

A) The team will make recommendations regarding the juvenile's placement in the community, supervision and treatment.

B) The team will engage the juvenile's family and/or caregivers in the process of decision making.

C) The team is responsible for ensuring that practices are guided and determined by the most current, empirically-based practices.

5) Decisions regarding any and all contact between the victim and the juvenile who committed the sexual offenses, including contact through family reunification, attendance at school, social activities and participation in treatment, will be based on community safety and the

well-being of victims and the recommendations of the multidisciplinary team.

6) Progress in treatment must be demonstrated by a change in the juvenile's behaviors and attitudes that support sex offending, the elimination of sex offending and an increase in pro-social and interpersonal skills.

Section 1910.20 Definitions

Accountability: Accurate attributions of responsibility, without distortion, minimization or denial. Quality of being responsible for one's conduct; being responsible for causes, motives, actions and outcomes.

Act: Illinois Sex Offender Management Board Act [20 ILCS 4026]

Aftercare: Placement, services and monitoring that commence at the point when the multidisciplinary team approves completion of primary treatment and readiness for accountability through a less restrictive supervision plan. Aftercare requires continued input by members of the multidisciplinary team. The aftercare plan is developed by the multidisciplinary team prior to the juvenile's completion of treatment and addresses strengths, risks, deficits relative to treatment completion, follow-up, placement, and supervision.

Assessment: Standardized measurements, developed and normed for juvenile populations, and clinical interviews used to evaluate various domains of functioning and development, including cognitive, psychological, emotional, memory and learning, social stability, family dynamics, academics, vocational/career and accountability.

Board: Sex Offender Management Board.

Completion of Treatment: A series of accomplishments, demonstrated competence, and mastery of both constructs and improved results on instruments used in treatment, as determined by the treatment provider in consultation with the multidisciplinary team. Specifically, the completion of treatment is defined by the offender's accomplishment of the following:

demonstrated accountability for and disclosure of all offenses to ensure that there are no unreported victims;

elimination of offending behavior;

acceptance of the presence and management of deviant thinking and impulses;

development of pro-social attitudes and behaviors;

increase in situational skills, i.e., communication, problem solving, and decision making; and

establishment of safety plans for school and home.

Contact: Any verbal, physical or electronic communication, whether direct or indirect, between a juvenile who has committed a sexual offense and a victim or a potential victim.

Purposeful: A planned experience with an identifiable potential outcome.

Incidental: Unplanned or accidental; by chance.

Dispositional Behavior: As a direct result of the successful completion of treatment, changes in the behavior, attitude and personality of the juvenile who committed the sex offense and in those elements of his/her behavior, attitude and personality that were present at the time of the offense and supported the offending behavior as a result of successful completion of treatment.

Evaluation: A sex-offender specific evaluation that systematically uses a variety of standardized measurements, assessments and information gathered collaterally and through face-to-face interviews. Sex-offender specific evaluations assess risk to the community; identify and document treatment and developmental needs, including safe and appropriate placement settings; determine amenability to treatment; and are the foundation of treatment, supervision, and placement recommendations.

Informed Assent: Assent means compliance; a willingness to do something in compliance with a request. The use of the word "assent" rather than "consent" recognizes that juveniles who have committed sexual offenses are not voluntary clients and that their choices are, therefore, more limited. Informed means a person's assent is based on a full disclosure of the facts needed to make the decision intelligently, e.g., knowledge of risks involved and the alternatives.

Informed Consent: Agreement including all of the following:

understanding what is proposed, based on age, maturity, developmental level, functioning, and experience, and mental status;

knowledge of societal standards for what is being proposed;

awareness of potential consequences and alternatives;

assumption that agreement or disagreement will be respected equally; and

voluntary decision to comply with recommendations.

Informed Supervision: Informed supervision is the ongoing, daily supervision and monitoring of a juvenile who has committed a sexual offense by an adult who:

is approved by the treatment provider;

is aware of the juvenile's history of sexually offending behavior;

does not deny or minimize the juvenile's responsibility for, or the seriousness of the sexual offense;

can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning;

is aware of the laws relevant to the sexual behaviors of juveniles;

is aware of the dynamic patterns associated with abusive behaviors and is able to recognize such patterns in daily functioning;

understands the conditions of community supervision and treatment;

can design, implement, and monitor safety plans for daily activities;

is able to hold the juvenile accountable for his/her behavior;

has the skills to intervene in and interrupt high risk patterns or behaviors;

can share accurate observations of daily functioning;

communicates regularly with members of the multidisciplinary team;

is not under the influence of alcohol or drugs or under professional care for mental health or substance abuse problems;

has not been convicted of or had any type of sexual abuse or offense allegations or charges substantiated by an official organization, agency or jurisdiction.

Juvenile: Any minor adjudicated for a sex offense under the jurisdiction of the juvenile court.

Milieu Therapy: A residential or day treatment program where employees interact with juveniles in a therapeutic manner regarding day-to-day living.

Multidisciplinary Team or MDT: The multidisciplinary team has primary responsibility for management and supervision of the juvenile through shared information and for monitoring the juvenile's progress in treatment and overall functioning in the various situations and environments that the youth encounters. The consensus of the MDT guides the development of recommendations regarding treatment, placement, and supervision. Members of the MDT should include the treatment provider, the supervising agent or officer, members of the juvenile's family, the caregiver, victim representative or advocate, school personnel, caseworker, law enforcement, coaches, employers or others who have relevant information about the juvenile.

Needs: Interpersonal issues to be addressed therapeutically or by specific intervention through treatment and the supervision plan.

Overall Health: Consists of personal and ecological aspects of a juvenile's life including physical, emotional, intellectual, social, relational, spiritual, educational, and vocational.

Potential Victim: A person who cannot reliably repel the unwanted sexual advances of the juvenile.

Recidivism: Return to sex offending after some period of abstinence or restraint. Recidivism may be measured by re-offenses that are self-reported or reported by a reliable informant, or by adjudication for subsequent sexual offenses.

Relapse Prevention: An element of treatment designed to address behaviors, thoughts, feelings, and fantasies that were present in the juvenile's instant offense, abuse cycle, and, consequently, relapse cycle. Relapse prevention is directly related to community safety. Evaluation of the individual's risk to re-offend shall be the basis of the safety plan and determine the level of supervision required.

Safety Planning: The purposeful planning of individualized, preventive interventions that the juvenile and others can use to moderate risks in specific situations and in day-to-day environments. The treatment provider shall develop the safety plan in consultation with the MDT. (Sample safety plans are available from the Board.)

Secondary or Indirect Victim: A family member or other person closely involved with the primary victim who is impacted emotionally and/or physically by the trauma suffered by the primary victim.

Sex Offense: An offense listed in Section 10(c) of the Sex Offender Management Board Act [20 ILCS 4026/10(c)].

Sex Offense Specific Treatment: A comprehensive set of planned therapeutic interventions and experiences to reduce the risk of further sexual offending and abusive behaviors by the juvenile. Treatment may include adjunct therapies to address the unique needs of the individual, but must include offense specific services by a treatment provider who meets the qualifications described in Section 1910.50. Treatment focuses on the situations, thoughts, feelings, and behavior that have preceded and followed past offending (abuse cycles) and promotes change in each area relevant to the risk of continued abusive, offending, and/or deviant sexual behaviors. Due to the heterogeneity of the juveniles who commit sex offenses, treatment is provided based on the individualized evaluation and assessment. Treatment is designed to stop sex offending and abusive behavior, while increasing the juvenile's ability to function as a healthy, pro-social member of the community. Progress in treatment is measured by change rather than the passage of time.

Sexual Abuse Cycle: A theoretical model of understanding the thoughts, feelings, behaviors, and events that fuel sex offending and abusive behavior.

Supervising Officer/Agent: A professional in the employ of State or county probation or parole, or the Departments of Corrections, Human Services, or Children and Family Services, who is responsible for community monitoring and case management.

Termination of Treatment: Removal from or stopping sex offense specific treatment due to changes in the juvenile's treatment needs, including but not limited to completion, lack of participation, increased risk, re-offense, or cessation of treatment that was mandated by the court for a specific period of time without successful completion of treatment.

Transition Point: Planned movement from one level of treatment and/or supervision to another.

Section 1910.30 Victim Centered Focus

a) The paramount goal of intervention with juveniles who commit sexual offenses shall be victim and community safety.

b) Victims shall have the exclusive right to determine the extent to which they will provide input to the management and treatment of the juvenile. Parents/guardians of the victim shall act on behalf of the victim to exercise this right in the best interest of the victim. (See 725 ILCS 120/4(a)(7).)

c) The only circumstance under which a victim and the perpetrator shall have contact or reside in the same home is when all other alternatives have been exhausted and:

1) there is a well-designed safety plan in place, which has been developed by an approved provider in collaboration with the MDT and its implementation is monitored by informed supervisors; and

2) the victim agrees, as expressed through an advocate for the victim.

d) Evaluation, treatment and supervision are intended to decrease recidivism among juveniles who commit sex offenses, thereby reducing the number of victims of sexual assault.

e) Treatment shall be clinically based with a clear plan to:

1) build on the youth's personal competencies;

2) improve the overall health of the juvenile and ensure that his/her environment promotes the development of internal and external resources to manage his/her sexual behavior; and

3) reduce recidivism.

SUBPART B: PROVIDER QUALIFICATIONS AND APPROVAL

Section 1910.40 Provider List

The Board will establish an approved provider list with the names of all individuals who are approved by the Board to provide evaluation and treatment of juvenile sex offenders, along with the category of services the providers are approved to provide (e.g., treatment or evaluation). Providers will be placed on the list if they complete the application process described in Section 1910.60, meet the requirements in Section 1910.50, and meet the qualifications and requirements that correspond to the designation sought.

a) Individuals who meet the qualifications of Section 1910.50(b) will be approved for conducting evaluations of:

1) Juveniles who have committed a sex offense that is a felony who are being considered for probation, pursuant to Section 16(b) of the Act; and

2) Juveniles found guilty of a sex offense pursuant to 705 ILCS 405/5-701.

b) Individuals who meet the qualifications of Section 1910.50(c) will be approved to provide sex offender treatment to any juvenile who is required to undergo treatment from a provider approved by the Board.

Section 1910.50 Provider Qualifications

a) General Requirements

1) An individual shall not provide evaluation or treatment services to juveniles who have committed sex offenses if he/she has:

A) been convicted of a felony;

B) been convicted of any misdemeanor involving a sex offense;

C) had a professional license placed on an inactive status, suspended, revoked or placed on probationary status for disciplinary reasons, unless the provider has been restored to full practice rights;

D) been found by any licensing body to have engaged in unethical or unprofessional conduct, unless the provider has been restored to full practice rights; or

E) been engaged in deceit or fraud in connection with the delivery of services or supervision or the documentation of their credentials.

2) A provider has a continuing duty to notify the Board if he/she becomes disqualified under this subsection (a).

b) Qualifications for Provision of Evaluations
Individuals who evaluate juveniles who have committed sex offenses must:

1) meet the definition of Licensed Practitioner of the Healing Arts (LPHA) as defined in 59 Ill. Adm. Code 132.25, which includes physicians licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 60]; advanced practice nurses with a psychiatric specialty licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]; clinical psychologists licensed under the Clinical Psychologist Licensing Act [225 ILCS 15]; licensed clinical social workers licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]; licensed clinical professional counselors licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or licensed marriage and family therapists licensed under the Marriage and Family Therapist Licensing Act [225 ILCS 55];

2) have 400 hours of supervised experience in the treatment/evaluation of sex offenders in the past 4 years, at least 200 of which are in face-to-face evaluation or treatment with juveniles who have committed sex offenses;

3) have completed at least 10 sex offender evaluations of juveniles who have committed sex offenses within the past 4 years; and

4) have at least 40 hours of documented training in the specialty of sex offender evaluation, treatment and management, 20 of which address juveniles who commit sex offenses, or work under the supervision of a provider who meets the requirements of this subsection (b).

c) Qualifications for Treatment Providers
Individuals who provide treatment must:

1) meet the definition of Licensed Practitioner of the Healing Arts (LPHA) as defined in 59 Ill. Adm. Code 132.25, which includes physicians licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 60]; advanced practice nurses with a psychiatric specialty licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]; clinical psychologists licensed under the Clinical Psychologist Licensing Act [225 ILCS 15]; licensed clinical social workers licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]; licensed clinical professional counselors licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or licensed marriage and family therapists licensed under the Marriage and Family Therapist Licensing Act [225 ILCS 55].

2) have 400 hours of supervised experience in the treatment of sex offenders in the past 4 years, at least 200 of which are in face-to-face treatment of juveniles who have committed sex offenses; and

3) have 40 hours documented training in the specialty of the evaluation, treatment and management of juveniles who have committed sex offenses, or work under the supervision of a treatment provider who meets the requirements of this subsection (c).

d) Career entrants (graduate or undergraduate students; trainees, interns and/or new employees) must have 20 hours of pre-service training and work under the supervision of a staff member who meets the requirements of subsections (a) and (b) or (c) of this Section.

e) Areas of training that will meet the requirements established in this Section include but are not limited to:

1) dynamics of juvenile sex offending

2) sexual assault cycle

3) prevalence of sexual assault

4) re-offense and risk of re-offense

5) offender characteristics

6) differences and similarities between juveniles and adults who commit sexual offenses

7) evaluation and assessment of juveniles

8) current professional research and practices

9) informed supervision: community management and supervision

10) interviewing skills

11) victim issues

12) sex offense specific treatment

13) qualifications and expectations of evaluators and treatment providers

14) relapse prevention

15) objective measurement tools

16) determining progress/outcome planning

17) denial

18) special needs populations

19) cultural, ethnic and gender awareness

20) family dynamics and interventions

21) developmental theory

22) trauma theory: secondary and vicarious

23) impact: professional's experience of secondary trauma

f) Client Records

1) Approved providers shall maintain client files in accordance with the professional standards of their individual disciplines and with Illinois law on health care records.

2) The contents of the case record shall reflect compliance with the standards of the Board.

Section 1910.60 Application

a) A provider seeking placement on the approved provider list must complete and submit to the Board an application form provided by the Board that contains the elements prescribed in this Section and identifies the services for which the provider seeks approval. The elements of the application include:

1) provider identification, including name, business address, telephone number, fax number and e-mail address;

2) a listing of the counties in which the applicant provides services;

3) a listing of any and all currently held licenses or certifications;

4) identification of any languages other than English in which the applicant is fluent and can provide services;

5) the applicant's separate attestations that none of the bars to eligibility listed in Section 1910.50(a)(1)-(5) apply;

6) separate attestations that the applicant meets each of the qualifications applicable to the types of service he or she will provide;

7) an agreement that the applicant will conduct sex offender evaluations and/or provide treatment in accordance with the requirements of this Part.

8) attestation that the applicant's submission of false information will result in removal from the approved provider list; and

9) an agreement to notify the Board immediately if the provider becomes ineligible under Section 1910.50(a)(1)-(5).

b) Applicants shall provide certified copies of degrees, licenses, certifications or any other documentation upon request of the application review committee.

c) Failure to provide any information requested by the committee, including certified copies of degrees, licenses or certifications, may result in denial of approval or removal from the approved provider list.

Section 1910.70 Application Review and Approval

Submitted applications will be referred to an application review committee, appointed by the Board, for review and approval.

a) The committee will consist of no fewer than 3 members, including one sex offense specific treatment provider, one sex offense specific evaluator, and one victim advocate.

b) No committee member holding a personal or financial interest in an application before the committee shall participate in the deliberation or the vote on approval of the application.

c) The committee shall review the application and, within 45 days after receipt of the application, shall either:

1) if it appears to the committee that all requirements for the type of approval applied for are met, direct that the applicant's name be added to the approved provider list and notify the applicant; or

2) if deficiencies are found in the application, notify the applicant of the deficiencies in writing. An application may be resubmitted after the deficiencies have been corrected.

Section 1910.80 Appeal of Application Denial

An applicant whose application for placement on the approved provider list is denied may appeal the decision of the application review committee by requesting review by the Board.

a) The request must be made in writing and received by the Board within 30 days after the denial was mailed to the business address supplied by the applicant.

b) The applicant must submit with the appeal all of the documentation necessary and available to support placement on the list.

c) Copies of the appeal, including supporting documentation, will be provided to each Board member, and the appeal shall be considered on the next regularly scheduled meeting of the Board held more than two weeks after receipt of the appeal.

d) The vote of the Board shall be final, and the Board will notify the applicant of the result within two weeks after the Board's action.

e) Individuals whose applications have been denied may re-apply when the circumstances leading to the original denial of placement on the approved provider list have substantively changed.

Section 1910.90 Removal from Provider List

The Board may rescind its approval of a person on the approved provider listing for any of the following reasons:

a) The provider was not, in fact, qualified for placement on the list at the time of application, but was placed on the list on the basis of false or erroneous information provided with the application.

b) Circumstances have changed so that the provider is no longer eligible for placement on the list under Section 1910.50(a).

c) The provider has substantially failed to follow the agreement to conduct evaluations and provide treatment in accordance with the requirements of this Part. For purposes of this Section, a substantial failure is one that is detrimental to the community and/or the juvenile who has committed a sex offense.

d) If a provider is removed from the list, the Board will inform any regulatory body with jurisdiction over the provider's professional license, if any.

Section 1910.100 Complaints Against Providers

Should any person have reason to believe that the Board's approval of a provider should be rescinded, the person may submit the concern to the Board in writing, together with any available documentation. Complaints will be reviewed in accordance with the procedures set forth in this Section.

a) The Board will refer the complaint to a committee it empowers for that purpose, and the committee will make a determination of whether the complaint alleges cause to rescind approval under Section 1910.90. The Board will notify the provider in question of receipt of a complaint and it nature, and if the complaint does allege cause to rescind, will request a written response from the provider within 30 days after receipt of the notice.

b) The committee shall review all information presented and determine whether the provider shall remain approved or whether approval shall be rescinded. The committee shall provide written notification of the decision, including the rationale, to the provider and the complainant within 30 days after the committee's receipt of the provider's response or, if there is no response, within 30 days after the committee's notification to the provider.

c) If the committee rescinds approval, it shall instruct the provider as to circumstances under which the provider may be reinstated.

d) For 35 days after the committee notifies the provider, the provider may appeal to the Board the decision of the committee to rescind approval. On appeal, the pertinent documentation shall be provided to the full Board for review at the next regularly scheduled meeting of the Board held more than 30 days after the receipt of the appeal. The provider shall have the opportunity to appear before the Board with respect to the appeal or, if unable to attend the meeting at which the matter is to be considered, to submit a statement to the Board. The provider shall be notified in writing of the decision of the Board within 30 days after Board consideration is complete.

e) The decision of the Board shall be final.

SUBPART C: STANDARDS OF PRACTICE

Section 1910.110 Ethical Standards

All providers of evaluation or treatment of juveniles who commit sex offenses subject to this Part are to adhere to the Ethical Principles in the Professional Code of Ethics (2001 Edition) published by the Association for the Treatment of Sexual Abusers (ATSA) (4900 S.W. Griffith Drive, Suite 274, Beaverton, Oregon 97005; Web: www.atsa.com). A copy of the Code is available at the Office of the Chair of the Board in the Office of the Illinois Attorney General, 100 W. Randolph St., 12th Floor, Chicago, Illinois 60601 or on the Board's web site at http://www.illinoisattorneygeneral.gov/communities/somb. This incorporation by reference does not include any later amendments or additions.

Section 1910.120 Confidentiality

a) Service providers shall notify all clients of the limits of confidentiality imposed by Illinois mandatory reporting requirements. (See the Abused and Neglected Child Reporting Act [325 ILCS 5].)

b) Juveniles who have committed sexual offenses and their parents or legal guardians shall be advised by the service provider to sign a consent for purposes of evaluation, treatment, supervision and case management, to protect victims or potential victims, and to support ongoing communication between members of the MDT.

c) In the absence of consent, the juvenile and parent/guardian must be fully informed by the service provider of alternative dispositions that may occur.

Section 1910.130 Evaluation

a) Juveniles who have been adjudicated for a sexual offense or for whom a continuance under supervision has been entered as a result of a sexual offense shall have a comprehensive evaluation.

b) The evaluation of juveniles who have committed sexual offenses has the following purposes:

1) To assess overall risk to the community;

2) To provide protection for victims and potential victims;

3) To provide a written clinical summary of the juvenile's strengths, risks, deficits, including any and all co-morbid conditions or developmental disorders;

4) To identify and document treatment and developmental needs;

5) To determine amenability for treatment;

6) To identify individual differences, potential barriers to treatment, and static and dynamic risk factors;

7) To make recommendations for the management and supervision of the juvenile; and

8) To provide information that can help identify the type and intensity of community based treatment, or the need for a more restrictive setting.

c) The evaluator shall describe to the juvenile and the parents or guardians evaluation methods, how the information will be used, with whom it will be shared and the nature of the evaluator's relationship with the juvenile and with the court.

d) The evaluator shall respect the juvenile's right to be fully informed about the evaluation procedures.

e) The evaluator shall review the results of the evaluation with the juvenile and the parent or guardian.

f) The evaluator shall disclose his/her responsibility as a mandated reporter to report suspected or known child abuse to the Department of Children and Family

Services and/or to make a referral to law enforcement if additional crimes have been committed by the juvenile being evaluated.

g) Evaluators shall select evaluation procedures relevant to the individual circumstances of the case and commensurate with their level of training and expertise.

h) Evaluation methods shall include the use of clinical interviews and procedures, screening level tests, self-report, observational data, advanced psychometric measurements, special testing measures, examination of juvenile justice information, psychological reports, mental health evaluations, school records, details of the offense, including victim statements, and collateral information, including the juvenile's history of sexual offending and/or abusive behavior. A combination of these shall be used to evaluate juveniles who commit sex offenses.

1) When clinically-indicated, evaluators may use physiological instruments such as the polygraph, plethysmograph or Abel Assessment so long as the instrument is suited for use with juveniles whose functioning is consistent with that of the juvenile being evaluated.

2) The provider must consult the MDT prior to the use of physiological instruments for juveniles who have committed sex offenses and are being evaluated.

Section 1910.140 Phases of Juvenile Evaluation

Evaluation shall occur in 5 phases:

a) Pre-trial investigation. The initial phase of information gathering shall involve law enforcement officers, child protective services, and other professionals deemed necessary for investigative purposes and management of community safety. Information and/or evaluations compiled before an admission of guilt are considered the least reliable and incomplete.

b) Presentence and post-adjudication evaluation. The evaluation focuses on dangerousness, risk, placement and amenability to treatment and must be completed prior to sentencing to identify the juvenile's level of dangerousness and risk, residential needs, level of care, and treatment referrals.

c) Ongoing needs assessment. Treatment planning and the juvenile's progress in treatment and compliance with supervision are reviewed on an ongoing basis. Level of risk shall be a critical consideration at transition points such as discharge from a residential treatment center to home or transfer from a campus school to a community school and includes considerations of level of functioning, monitoring, and follow-up.

d) Release or termination evaluation. Prior to discharge from treatment or a residential treatment center or when the level of care changes, e.g., upon release from DOC, the evaluation is updated with a focus on community safety, reduced risk, and successful application of treatment tools. The final evaluation report shall make recommendations for follow-up and aftercare services.

e) Follow-up/monitoring. Probation/parole or other supervising agents or the caseworker must continue monitoring the juvenile's level of risk and treatment needs for as long as the court retains jurisdiction.

Section 1910.150 Elements of Juvenile Evaluation

a) Evaluation of juveniles who have committed sexual offenses shall be comprehensive and ongoing. The evaluator shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical, and/or educational issues that may arise during the evaluation.

b) The comprehensive evaluation shall assess the juvenile in the following areas:

1) cognitive functioning, including educational history;

2) personality, mental health, mental disorders;

3) social/developmental history;

4) current individual functioning;

5) current family functioning;

6) sexual background and history, to include function and dysfunction;

7) delinquency and conduct/behavioral issues, including substance or alcohol abuse;

8) assessment of risk to re-offend;

9) community risks and protective factors;

10) victim impact;

11) external relapse prevention strategies, including informed supervision; and

12) amenability to treatment.

Section 1910.160 Evaluation Recommendations and Report

a) Recommendations regarding intervention shall be based on a juvenile's level of risk and needs as determined by the sex offender-specific evaluation.

b) Evaluation reports shall be provided in writing to members of the MDT, provided that consent has been given.

c) Evaluation reports shall:

1) describe the juvenile's strengths, deficits, risks for re-offense and all co-morbid conditions and/or developmental disorders;

2) recommend the management and supervision strategies for the juvenile;

3) recommend the type and intensity of treatment; and

4) recommend placement options that protect victims and potential victims ranging from placement in a family home through secure care in a locked facility.

Section 1910.170 Treatment

a) The primary treatment provider, in consultation with the MDT, shall refer juveniles living in the community, residential treatment programs, or correctional facilities for individual, group, or family therapy or other adjunct services.

b) Sex offense specific treatment shall be designed to address strengths, risks and deficits and all areas of need identified by the evaluation (described in Section 1910.60) and shall:

1) provide for the protection of past and potential victims and protect victims from unsafe or unwanted contact with the juvenile;

2) include treatment goals and interventions that are individualized to improve individual and family functioning and enhance the abilities of support systems to respond to the juvenile's needs and concerns;

3) favor continuity in caregiver relationships;

4) implement interventions that address the juvenile's need for pro-social peer relationships, activities, and success in educational/vocational settings;

5) define participation and informed supervision expectations for the juvenile, the family/caregivers, educators, and members of the juvenile's support systems;

6) develop detailed, long-term relapse prevention, safety, and aftercare plans to address risks and deficits that remain unchanged; and

7) describe relevant and measurable outcomes that will be the basis of determining successful completion of treatment.

Section 1910.180 Treatment Provider – Juvenile Contracts and Consent Agreements

a) Providers shall develop and utilize a written treatment contract and consent agreement with each juvenile who has committed a sexual offense prior to the commencement of treatment.

b) Treatment contracts and consent agreements shall address victim and public safety and shall be consistent with the conditions of the supervising agency. The treatment contract and consent agreement shall define the specific responsibilities and rights of the provider, and shall be signed by the provider, parent/guardian, and the juvenile. (Sample treatment plans are available from the Board.)

c) At a minimum, the treatment contract and consent agreement shall explain the responsibility of a provider to:

1) define and provide timely statements of the applicable costs of evaluation, assessment, and treatment, including all medical and psychological testing, physiological tests, and consultations;

2) describe the waivers of confidentiality, describe the various parties, including the MDT, with whom treatment information will be shared during the course of treatment, and inform the juvenile and parent/guardian that information may be shared with additional parties on a need to know basis;

3) describe the right of the juvenile or the parent/legal guardian to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and the potential outcomes of that decision;

4) describe the procedure necessary for the juvenile or the parent/legal guardian to revoke the waiver and describe the relevant time limits;

5) describe the type, frequency, and requirements of treatment and outline how the duration of treatment will be determined; and

6) describe the limits of confidentiality imposed on providers by Illinois statutes on mandatory reporting [325 ILCS 5/4].

d) At a minimum, the treatment contract and consent agreement shall explain the responsibilities of the juvenile and his/her parent/guardian and shall include but are not limited to:

1) compliance with the limitations and restrictions placed on the behavior of the juvenile as described in the terms and conditions of diversion,

probation, parole, Department of Human Services, community corrections, or the Department of Corrections, and/or in the terms of the agreement between the provider and the juvenile;

2) compliance with conditions that provide for the protection of past and potential victims, and that protect victims from unsafe or unwanted contact with the juvenile;

3) participation and progress in treatment;

4) payment for the costs of evaluation and treatment of the juvenile and family, if family treatment is identified as a treatment need in the evaluation;

5) notification of third parties (i.e., employers, partners, etc.); and

6) notification of the treatment provider of any relevant changes or events in the life of the juvenile or the juvenile's family/support system.

Section 1910.190 Treatment Plans

a) Providers, in concert with the MDT, shall develop written treatment plans with measurable goals based on the individualized evaluation and assessment of the juvenile.

b) Sex offense specific treatment methods and intervention strategies shall be used and shall include a combination of individual, group and family therapy unless contraindicated.

c) The treatment plan shall be reviewed by the treatment provider and the MDT at a minimum of every three months or at each transition point, and revisions shall be made as indicated by the youth's progress in treatment.

Section 1910.200 Treatment Methods

a) Sex offense specific treatment shall focus on eliminating abusive behavior by decreasing deviant thinking, impulses, and dysfunction; restructuring distorted thinking patterns that are supportive of continued offending; and improving overall health with the goal of decreased risk.

b) Sex offense specific treatment and intervention strategies shall be used and include a combination of individual, group, and family therapy unless contraindicated.

c) When clinically indicated, the provider may use physiological instruments such as the polygraph, plethysmograph, or Abel Assessment of Sexual Interests so long as the instrument is suited for use with juveniles whose functioning is consistent with that of the juvenile receiving treatment.

d) Empirically-supported treatment modalities currently indicated by research to be best practice based on treatment outcomes are preferred. The following are the preferred practices:

1) Individual therapy shall be used to address sex offense specific issues and attendant mental health issues, if present, and/or to support the juvenile in addressing issues in group, family, or milieu therapy. Provider to client ratio shall be 1:1.

2) Group therapy, proven to be one of the most effective treatment modalities for juveniles, is recommended and may be used to provide psycho-education, promote development of pro-social skills, and provide positive peer support. It may also be used for group process. Provider to client ratios shall be no less than 1:8 or 2:12.

3) Family therapy addresses family systems issues and dynamics. This model shall address, at a minimum, informed supervision, therapeutic care, safety plans, relapse prevention, reunification, and aftercare plans. Provider to client ratios shall be no less than 1:8 or 2:12. Because victims of juveniles who have committed sex offenses are often family members (e.g., younger siblings or foster siblings), the following conditions must be met prior to the initiation of family therapy:

A) The parent or guardian must give consent;

B) The victim must be receiving victim advocacy services, including therapy, and agree to participate in family therapy;

C) A child advocate for the victim must approve the victim's participation in family therapy in writing; and

D) The approved service provider, along with the MDT, has considered the risk of re-traumatization of the victim by having contact with the juvenile who committed the sex offense, and concluded that family therapy would be beneficial. Offender accountability and the assignment of responsibility are major determinants of whether family contact occurs.

4) Multi-family groups provide education, group process, and/or support for the parent and/or siblings of the juvenile. Inclusion of the juvenile is optional.

A) The treatment provider is responsible for establishing and maintaining confidentiality.

B) Staff to client ratios shall be designed to provide safety for all participants.

C) Provider to client ratios shall be no less than 1:8; 2:15; 3:18; or 4:24.

5) Psycho-education is required to teach definitions, concepts, and pro-social skills and must be offered in a group setting. Provider to client ratios shall be no less than 1:12 or 2:20.

6) Milieu therapy is used in residential treatment settings to supervise, observe, and intervene in the daily functioning of the juvenile. Provider to client ratios shall not be less than the following: 1:8 for juveniles 10-12 years of age; 1:10 for juveniles 13 years old and older.

7) Dyadic therapy is used when the treatment provider deems it beneficial and clinically appropriate.

8) Self-help or time limited treatments are used as adjuncts to enhance goal oriented treatment. Adjunct treatments must be complementary to sex offense specific treatment.

Section 1910.210 Progress Review and Discharge

a) At least quarterly, and in advance of planned discharge, the treatment provider shall convene the MDT to appraise the youth's progress in treatment and update the treatment plan based on progress reports from the treatment provider.

b) Discharge/termination recommendations shall be based on the youth's progress in treatment, improved functioning in home, school, and community, compliance with the safety plan, and acceptance of responsibility for the sex offense.

Section 1910.220 Successful Completion of Treatment

a) Successful completion of sex offense specific treatment requires the following:

1) accomplishment of all of the goals identified in the treatment plan;

2) demonstrated application in the juvenile's daily functioning of the principles and tools learned in sex offense specific treatment;

3) consistent compliance with treatment conditions;

4) consistent compliance with supervision terms and conditions; and

5) a completed written relapse prevention and aftercare plan that addresses remaining risks and deficits, and that has been reviewed and agreed upon by those responsible for the juvenile's treatment, care, support, supervision, and monitoring, including the MDT, the family and the community support system.

b) Any exception made to any of the requirements for successful completion of treatment shall be made by the treatment provider in consultation with the MDT. The treatment provider shall document the reasons for the determination that treatment has been completed without meeting all treatment requirements and note the potential risk to the community.

c) Based on a determination by the treatment provider and MDT, juveniles who pose an ongoing risk of harm to the victim or community, even though determined to have successfully completed treatment, will require ongoing supervision and/or treatment to manage their risk in aftercare as they re-integrate into the community.

d) The supervising officer/agency may seek a means of continued court ordered supervision, i.e., extension or revocation and re-granting of probation/supervision for a juvenile who has been otherwise compliant but has not achieved his/her treatment goals by an approaching supervision expiration date.

e) If the juvenile is no longer under the authority of the juvenile court, poses a known risk to others in the community, and is beyond the control of his or her parent, guardian or custodian, the treatment provider shall convene the MDT to consider petitioning the juvenile court to adjudicate the minor a "minor requiring of authoritative intervention".

f) If supervision is not continued and the juvenile has not completed treatment, the discharge summary shall note the continued risks and delineate the requirements for the juvenile's registration as a sex offender.

g) The MDT shall not recommend termination of sex offense specific treatment without completion. When the approved provider and the MDT have determined that a juvenile is not making progress and will not benefit from continued sex offense specific treatment, the juvenile shall be referred to the referring or placing agent for further action.

SUBPART D: SUPERVISION, RISK MANAGEMENT AND ACCOUNTABILITY

Section 1910.230 Multidisciplinary Team

The purpose of the MDT is to supervise and monitor the juvenile through shared information. The MDT may include clinical providers, supervising agents, parents or caregivers, and others who have relevant information about the juvenile. The information that is gathered is the basis of the ongoing assessment of risk, identifies any changes in the youth's clinical needs or need for supervision, and documents the juvenile's progress in treatment. The MDT meets at least quarterly.

a) The MDT may make recommendations regarding:

1) the juvenile's evaluation, treatment, treatment plan, safety plan, placement, and supervision;

2) any change in the level of supervision and/or in the juvenile's placement; and

3) any proposed contact between the victim and the juvenile who committed the sexual offense.

b) After adjudication or a continuance under supervision has been entered, and a referral to probation, parole, or out-of-home placement has been made, the MDT may be convened by the treatment provider, the supervising agent or the caseworker if one is assigned.

c) The convener of the MDT shall invite the following individuals to team meetings:

1) a designee from the supervising office/agent;

2) Department of Children and Family Services caseworker, if the Department is responsible for the juvenile;

3) the juvenile's caregiver (parent, guardian, residential placement representative);

4) the sex offense specific treatment provider (outpatient or residential) and all other clinical services providers;

5) the polygraph examiner, when utilized;

6) victim representative or advocate; and

7) others who can provide relevant information to the MDT.

d) At the first meeting, members of the MDT shall determine:

1) whether others are necessary to the composition of the MDT;

2) the frequency of MDT meetings:

A) if the schedule is different from the required quarterly meeting;

B) if meetings are scheduled because of a change in the youth's placement or level of supervision; or

C) if there is proposed contact with the victim;

3) the content and goals of team meetings, including the information that will be exchanged; and

4) who is responsible for maintaining records of the MDT's recommendations, decisions and actions.

Section 1910.240 Placement

a) The three goals of placement shall be the protection of victims and potential victims, community safety, and, as a part of treatment, building the competencies of the juvenile.

b) Unless there is a court order regarding a juvenile's placement, placement recommendations shall be developed collaboratively by the treatment provider and other members of the MDT. The MDT shall consider whether the placement is the least restrictive setting that can provide adequate supervision, structure, and treatment to prevent future offending behavior.

c) Parents or designated caregivers in any placement setting shall be informed about the juvenile's offense history, identified risks, treatment plan, and supervision needs. Placement should occur only if the parent/caregiver understands and agrees to comply with all supervision requirements.

d) Placement decisions and placement review shall be based on an appraisal of the juvenile's level of risk and clinical needs identified during the evaluation.

Section 1910.250 Polygraph Examinations of Juveniles

a) The approved provider, in consultation with the MDT, shall refer juveniles for polygraph examinations when therapeutically indicated.

b) Prior to administering a polygraph, the polygraph examiner shall make the final determination of the juvenile's suitability for polygraph examination based on factors such as developmental and cognitive functioning, mental health, etc.

c) The type and frequency of polygraph testing and the use of polygraph results in treatment and supervision shall be documented in the case record.

d) Before commencing any polygraph examination with any juvenile who has committed a sexual offense, the polygraph examiner shall document that the juvenile, at each examination, has been provided a thorough explanation of the polygraph examination process and the potential relevance of the procedure to the juvenile's treatment and/or supervision. Review and documentation of informed assent will include information regarding the juvenile's right to terminate the examination at any time and to speak with his/her attorney if desired.

Section 1910.260 Accountability and Assignment/Acceptance of Responsibility

a) As an integral component of treatment, offenders are expected to establish their accountability, describe the nature of their behavior, and list what steps they have taken to accept responsibility for the offense in accountability sessions with others (i.e., victim's parents, family members, siblings, neighbors, fellow students).

b) Assignment of the offender's accountability and responsibility for the offense is a process designed primarily to benefit the victim.

1) Assignment of responsibility is a lengthy process that occurs over time, usually beginning with the juvenile's reduction of denial and ability to accurately self-disclose about the offending behavior.

2) Information gained as a result of a specific issue polygraph is critical to the assignment of responsibility to the offender.

c) The offender accountability process and the assignment of responsibility must be approved by the treatment provider in consultation with the MDT and specifically include the victim's therapist or an advocate. The following criteria shall be used to determine whether the accountability/assignment of responsibility process shall occur.

1) The victim requests offender accountability and assignment of responsibility and the victim's therapist or advocate concurs that the victim would benefit.

2) Parents/guardians of the victim (if a minor) and the juvenile offender are informed of and give approval for the accountability process and assignment of responsibility.

3) The juvenile evidences empathic regard through consistent behavioral accountability, including an improved understanding of the victim's perspective, the victim's feelings, and the impact of the juvenile's offending behavior.

4) The juvenile is able to acknowledge the victim's statements without minimizing, blaming, or justifying.

5) All of the juvenile's statements should transfer any responsibility for the offense from the victim and to him/herself. The juvenile is prepared to answer questions, make a clear statement of accountability, and describe the rationale for victim selection to remove guilt and perceived responsibility from the victim.

6) The juvenile is able to demonstrate the ability to manage abusive or deviant sexual interest/arousal specific to the victim.

7) Any sexual impulses are at a manageable level and the juvenile can utilize cognitive and behavioral interventions to interrupt deviant fantasies as determined by continued assessment.

d) The MDT may:

1) collaborate with the victim if age appropriate, victim's therapist or advocate, guardian, custodial parent, foster parent and/or guardian ad litem in making decisions regarding communication, visits, and reunification, in accordance with court directives.

2) support the victim's wishes regarding contact with the juvenile to the extent that it is consistent with the victim's safety and well-being.

3) arrange contact in a manner that places victim safety first. The psychological and physical well-being shall be a primary consideration.

e) Contact between the victim and the juvenile who has committed the sex offense is first initiated through the process of assigning accountability and responsibility.

f) Contact includes verbal or non-verbal communication, which may be indirect or direct, between a juvenile who has committed a sexual offense and a victim.

g) Following commencement of the accountability/assignment of responsibility process and with the consensus of the approved provider and the MDT, contact may progress to supervised contact with an informed supervisor outside of a therapeutic setting.

Section 1910.270 Family Reunification

a) A goal of family reunification may be established only if victim safety and continued recovery can be assured.

b) The treatment provider, in collaboration with the MDT, shall make recommendations regarding reunification.

1) Family reunification shall never take precedence over the safety of any victim.

2) If reunification is indicated, after careful consideration of all the potential risks, the process shall be closely monitored by the approved provider and the MDT.

c) Reunification may be considered only when all of the following conditions are met:

1) the offender has accepted full responsibility for the offense;

2) the victim has received treatment and an advocate for the victim concurs with reunification;

3) the treatment provider and the MDT conclude that the juvenile has made significant progress toward goals and outcomes as evidenced in the quarterly review by the MDT; and

4) the treatment provider and the MDT have determined that the parent/guardian has demonstrated the ability to provide informed supervision and:

A) the parent/guardian demonstrates the ability to initiate consistent communication with the victim regarding the victim's safety;

B) the family believes the abuse occurred, has received support and education, and accepts that potential exists for future abuse or offending; and

C) the family has established a relapse prevention plan that extends into aftercare and includes evidence of a comprehensive understanding of the offending behaviors and implementation of safety plans.

d) With the MDT, the treatment provider shall continue to monitor family reunification and recommend services according to the treatment plan.

1) Family reunification does not indicate completion of treatment.

2) Reunification may illuminate further or previously un-addressed treatment issues that may require amendments to the treatment plan.